GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 23, 2024

Laura Brosius and Alexis Brosius
5845 Lum Rd
Attica, MI 48412

RE: License #:	AF440410099
Investigation #:	2024A0872032
	Angelic Gardens

Dear Laura Brosius and Alexis Brosius:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AF440410099
Investigation #:	2024A0872032
Complaint Receipt Date:	04/09/2024
Investigation Initiation Date:	04/09/2024
Report Due Date:	06/08/2024
Licensee Name:	Laura Brosius and Alexis Brosius
Licensee Address:	5845 Lum Rd ATTICA, MI 48412
Licensee Telephone #:	(810) 357-6730
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Angelic Gardens
Facility Address:	5845 Lum Rd Attica, MI 48412
Facility Telephone #:	(810) 721-2378
Original Issuance Date:	04/08/2022
License Status:	REGULAR
Effective Date:	10/08/2022
Expiration Date:	10/07/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident B uses a Hoyer lift that requires two people, but the owners make staff do it by themselves.	No
On one occasion, Resident A had to administer her own insulin without staff assistance.	No
Additional Findings	Yes

III. METHODOLOGY

04/09/2024	Special Investigation Intake 2024A0872032
04/09/2024	APS Referral An APS complaint was made via email
04/09/2024	Special Investigation Initiated - Letter An APS complaint was made
05/07/2024	Inspection Completed On-site Unannounced
05/10/2024	Contact - Telephone call made I interviewed Relative A1
05/12/2024	Contact - Face to Face I interviewed Resident A via Zoom
05/15/2024	Contact - Document Sent I emailed the licensee requesting information related to this complaint
05/20/2024	Contact - Telephone call received I spoke to the licensee, Laura Brosius about this complaint
05/21/2024	Contact - Document Received AFC documentation received
05/23/2024	Contact - Telephone call made I interviewed Resident B's hospice nurse, Jamie Boyd

05/23/2024	Exit Conference I conducted an exit conference with the licensee, Laura Brosius
05/23/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident B uses a Hoyer lift that requires two people, but the owners make staff do it by themselves.

INVESTIGATION: On 05/07/24, I conducted an unannounced onsite inspection of Angelic Gardens Adult Foster Care facility. I interviewed staff, Janet Schalau, licensee (LD) Alexis Brosius, Resident B, and Relative B1. I also observed three other residents who were clean, dressed appropriately, and supervised by staff.

Staff Schalau and LD Brosius confirmed that Resident B uses a Hoyer lift for transfers which was prescribed by his physician. According to Staff Schalau and LD Brosius, all staff has been trained in the use of the Hoyer lift and they use the lift as instructed by Resident B's doctor. According to Staff Schalau and LD Brosius, one staff can transfer Resident B from his bed to his chair, but it requires two staff to bathe him. LD Brosius said that Resident B has a home health aide who comes to the facility approximately twice a week to give him a bed bath. LD Brosius said that if Resident B ever requires two staff to transfer him, two staff are always available to do so. LD Brosius and Staff Schalau said that Resident B is always transferred properly, and he has never fallen or had an accident from improper use of his Hoyer lift.

Resident B and Relative B1 were in Resident B's bedroom, listening to a musician who brought her guitar in to entertain the residents. Relative B1 confirmed that Resident B uses a Hoyer lift for transfers, and she confirmed that one staff can transfer him from his bed to his chair. Relative B1 told me that she has witnessed staff transfer Resident B on numerous occasions and they have always done so appropriately. Relative B1 confirmed that if staff needs assistance with transferring Resident B, they ask another staff for help. Relative B1 also confirmed that Resident B has a home health aide who comes to the facility twice a week to bathe him. Relative B1 said that she does not have any concerns about the care that Resident B receives at this AFC home.

On 05/20/24, I spoke to the licensee designee (LD), Laura Brosius about this complaint. LD Brosius confirmed that Resident B requires a Hoyer lift for transfers. She said that shortly after Resident B moved into her home, he was placed on hospice care. Hospice took over his care and they have been providing home care services for him since then. LD Brosius said that Resident B's hospice nurse ordered the Hoyer lift for him, and she provided a training for all staff, on how to safely use the lift. LD Brosius confirmed that Resident B only requires one staff to transfer him from his bed to his chair. She said that since his hospice nurse bathes him twice a week, her staff are not required to transfer him for showers which would require two staff.

On 05/22/24, I reviewed AFC paperwork related to Resident B. He was admitted to Angelic Gardens AFC on 08/23/23. According to his Assessment Plan dated 08/13/23, Resident B is unable to ambulate on his own and is bed/chair bound. He requires 1-staff assistance with transfers, toileting, bathing, and personal hygiene. He wears briefs and uses a bedside commode. He has a wheelchair, hospital bed, and Hoyer lift. I reviewed an order from Residential Home Health and Hospice for Resident B's Hoyer lift, signed by Dr. Mohammad Nodeemullah. The order states "Remove Hoyer sling at bedtime to promote comfort and skin integrity." It does not specify how many staff are required to use the Hoyer lift.

On 05/23/24, I interviewed Resident B's hospice nurse (RN), Jamie Boyd via telephone. RN Boyd confirmed that Resident B uses a Hoyer lift for transfers, and she confirmed that staff has been trained in the proper use of the Hoyer lift. RN Boyd said that one staff can transfer Resident B from his bed to his recliner and said that if staff needed to take him to the bathroom or into another room, two staff should complete the transfer. RN Boyd told me that she has observed staff use the Hoyer lift for Resident B and she feels they have been trained properly and they use the Hoyer lift appropriately. RN Boyd said that she does not have any concerns about the care Resident B receives at this facility.

APPLICABLE RULE	
R 400.1416	**Resident healthcare.**
	(1) A licensee, in conjunction with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician regarding medications, special diets, and other resident healthcare needs that can be provided in the home.
ANALYSIS:	Staff Janet Schlaud, LD A. Brosius, LD L. Brosius, Relative B1, and RN Jamie Boyd all stated that one staff is capable of transferring Resident B from his bed to his recliner using the Hoyer lift. Staff Schlaud, LD A. Brosius, LD L. Brosius, and RN Boyd said that staff has been trained in the proper use of the Hoyer lift and staff uses it correctly. Resident B's Assessment Plan and the physician's order for his Hoyer lift does not specify that two staff are needed when transferring Resident B. I conclude that there is insufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On one occasion, Resident A had to administer her own insulin without staff assistance.

INVESTIGATION: On 05/07/24, I conducted an unannounced onsite inspection of Angelic Gardens Adult Foster Care facility. I interviewed staff, Janet Schalau, licensee (LD) Alexis Brosius, Resident B, and Relative B1. I also observed three other residents who were clean, dressed appropriately, and were supervised by staff.

Staff Schalau and LD Brosius said that Resident A lived at this facility for over a year, and she was recently transferred to Suncrest nursing home due to insurance reasons. They confirmed that Resident A was prescribed insulin in an injectable form. When it was time for her to take her insulin, staff would obtain the insulin pen, hand it to Resident A who would then self-inject the medication and hand the insulin pen back to staff. Staff Schalau and LD Brosius said that although Resident A administered her own insulin, staff always supervised and put the insulin pen back in the locked medication cabinet when she was through. Staff Schalau and LD Brosius said that there were never any occasions when Resident A was given her own insulin pen without staff supervision, and she never had to ask any of the other residents for help.

While at the facility, Staff Schalau and LD Brosius showed me the locked medication cabinet and confirmed that staff keeps the key on their person. They said that the residents in this facility have dementia, physical disabilities, and/or are aged and none of them would be able to assist each other with medications or personal care. They stated that there is always at least one staff always supervising the residents.

On 05/10/24, I interviewed Relative A1 via telephone. Relative A1 confirmed that Resident A resided at Angelic Gardens for approximately one year and she was prescribed injectable insulin by her doctor. Relative A1 said that staff kept the insulin in the locked medication cabinet. When it was time for Resident A to take her insulin, staff would hand her the insulin pen, she would inject it, hand the pen back and staff would lock the insulin pen back up. Relative A1 said that staff always supervised Resident A when she took her medication, and she does not believe that Resident A ever asked any of the other residents for help. Relative A1 said that Resident A received great care while she resided at Angelic Gardens and the only reason, they moved her to Suncrest nursing home is because their insurance would no longer cover the AFC home.

On 05/12/24, I interviewed Resident A via facetime with the assistance of Relative A1. Resident A confirmed that she resided at Angelic Gardens, but she does not know for how long. Resident A confirmed that she takes injectable insulin for diabetes and confirmed that she would inject her own insulin after being handed the pen by staff. Resident A told me that she never had to ask any of the other residents for help with her medications and said that staff was always available. Resident A told me that staff took good care of her while a resident of Angelic Gardens and she does not have any concerns or complaints.

On 05/20/24, I spoke to the licensee (LD), Laura Brosius, about this complaint. She confirmed that while Resident A resided at her home, she was prescribed injectable medication for diabetes. LD Brosius said that staff would hand the injection to Resident A, she would inject it and hand it back to staff. LD Brosius said that Resident A was never left unsupervised with the medication, and she never asked any of the residents for assistance.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise, all the giving, taking, or application of prescription medications shall be supervised by the licensee or responsible person.
ANALYSIS:	Staff Janet Schlaud, LD A. Brosius, LD L. Brosius, Relative A1, and Resident A said that Resident A is prescribed injectable insulin by her doctor. All individuals said that staff hands Resident A the injection, she administers it, and she hands the injection back to staff. All individuals stated that Resident A has never had to administer her own insulin without the assistance and supervision of staff. I conclude that there is insufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While conducting this investigation, I asked LD Brosius for a copy of Resident B's Health Care Appraisal. On 05/20/24, LD Brosius said that although she asked Resident B's physician for the completed health care appraisal, he has not completed it as of this date. Resident B was admitted to this facility on 08/23/23.

APPLICABLE RULE	
R 400.1416	**Resident healthcare.**
	(2) A licensee shall maintain a healthcare appraisal on file for not less than 2 years after the resident's admission to the home.

ANALYSIS:	While conducting this investigation, I asked LD Brosius for a copy of Resident B's Health Care Appraisal. On 05/20/24, LD Brosius said that although she asked Resident B's physician for the completed health care appraisal, he has not completed it as of this date. Resident B was admitted to this facility on 08/23/23. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/23/24, I conducted an exit conference with the licensee, Laura Brosius. I told her the results of my investigation and explained which rule violation I am substantiating. I asked LD Brosius to complete and submit a corrective action plan upon the receipt of my investigation report.

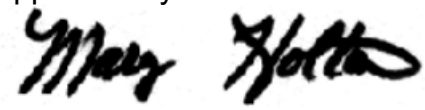
IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

May 23, 2024

Susan Hutchinson Licensing Consultant	Date

Approved By:



May 23, 2024

Mary E. Holton Area Manager	Date